cantly increased during last five years. There is a need for prevention, treatment and disease management programs to lower the medical and socioeconomic burden of this disease.

Urinary/Kidney Disorders – Research on Methods

PUK15

A SIMULATION MODEL OF THE EFFECTS OF TREATMENTS FOR SECONDARY HYPERPARATHYROIDISM ON MORTALITY

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OBJECTIVES: Secondary hyperparathyroidism (SHPT) is a common condition in dialysis, characterized by high levels of associated laboratory parameters (LABS): parathyroid hormone (PTH), serum calcium (Ca) and phosphorous (P). Cinacalcet can be effective in controlling LABS in SHPT. Objective of this study was to develop a model to simulate the impact of cinacalcet versus standard treatment (ST) on patient mortality. **METHODS:** The model used the latest data on cinacalcet efficacy in lowering LABS from the OPTIMA and ADVANCE interventional trials together with the estimated relationship between LABS and mortality from the ARO observational study on 7970 haemodialysis patients treated in European Fresenius Medical Care facilities. Patient-level data from the 6-month OPTIMA and 12-month ADVANCE studies were pooled and regression models were fitted with post-treatment values as the response to derive functions predicting 12-month LABS values from their starting values, patient characteristics and treatment. After 12 months LABS were assumed constant except for PTH in ST (assumption of a 170 pg/ml per year increase). Mortality was calculated as that of the dialysis population multiplied by relative risks as function of LABS. The model was compared with a Block observational study analyzing mortality rates (26-month follow-up) in 19,186 haemodialysis patients treated at the DaVita dialysis provider in the US. The simulation was run with patient characteristics replicating the DaVita cohort and base mortality rates from the US Renal Data System. **RESULTS:** The simulated death rates (year 1: cinacalcet 18.4%, ST 22.6%, RR=0.81; year 2: cinacalcet 32.9%, ST 40.8%, RR=0.81) were close to the observed data in the Block study (year 1: cinacalcet 15%, ST 20%, RR=0.75; year 2: cinacalcet 30%, ST 37%, RR=0.81). **CONCLUSIONS:** The model showed effects of cinacalcet on mortality similar to those observed in the DaVita US cohort. This mortality model will be a useful tool for future health-economic analyses of cinacalcet in SHPT.

PUK16

KNOWN-GROUP VALIDITY OF THE SPANISH VERSION OF THE SHORT-FORM OVERACTIVE BLADDER HEALTH RELATED QUALITY OF LIFE QUESTIONNAIRE (OABQ-SF) IN SUBJECTS WITH OVERACTIVE BLADDER

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OBJECTIVES: To explore the known-group validity of the Spanish version of the self-administered OABq-SF questionnaire, which feasibility, reliability and construct and criterion validities have previously been shown. **METHODS:** The culturally adapted Spanish version of OABq-SF was administered on two occasions 3 months apart to a set of patients of both genders, >18 years, diagnosed of OAB according with standard criteria and a score > 8 in OAB-V8 scale and able to understand and filling-in PRO instruments written in Spanish. Patients were recruited consecutively at clinics of Urology all over the country. Known-groups validity was explored using the sample of patients classified in quartiles according to their responses in the OAB-V8 scale at the baseline visit. Patients were compared in the OABq-SF: symptom bother and HRQoL. For known-group testing purposes, baseline scores in the OABq-SF questionnaire were used. ANOVA, descriptive statistics and Pearson's r coefficients were computed for data analysis. **RESULTS:** The study enrolled a total of 246 OAB patients (mean age 57.7 years; 76% women, 99% Caucasian, 37% active workers and 36% primary schooling) at 18 urological. OAB-V8 scores significantly correlated (Pearson's r coefficient) with OABq-SF domains; +0.790 and −0.659 for symptom bother and HRQoL domains, respectively ($p<0.001$ in both cases). Mean (95% CI) of the OABq-SF domain scores were significantly different between OAB-V8 quartile groups; 39.1 (36.0-42.3), 48.0 (44.5-51.5), 56.7 (53.6-59.8) and 74.6 (71.4-77.7) points for 1st, 2nd, 3rd and 4th quartile groups, respectively ($F=10.5$, $p<0.001$) in symptom bother domain, and 66.8 (6.1-70.5), 60.5 (56.4-64.6), 53.5 (49.9-57.2) and 37.8 (34.0-41.6) points average score, respectively ($F=32.9$, $p<0.001$) in HRQoL domain. **CONCLUSIONS:** The Spanish version of the OABq-SF instrument provided evidence of known-group validity according with patient-rated severity of symptom bother in the OAB-V8 scale.

POSTER SESSION II
HEALTH CARE USE & POLICY STUDIES

Health Care Use & Policy Studies – Consumer Role In Health Care

PHP1

IMPROVING PATIENT SAFETY IN THE UK AND ENGAGING PATIENTS IN RESEARCH: A NEW MODEL FOR THE NHS?

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OBJECTIVES: The purpose of this study was to determine awareness of and interest in research amongst members of a web-based medicines monitoring service and to solicit opinions on whether this service should be offered by the NHS. **METHODS:** In May 2011, we surveyed 150 uk.MediGuard.org members: 50 in England, Scotland, and Wales. uk.MediGuard.org is a free medicines monitoring service covering over 2.5 million patients, including 100,000 in the UK. **RESULTS:** Ninety-one percent of respondents rate the MediGuard service as good or excellent and 99% are unaware of similar services in the UK. When asked whether the National Health Service (NHS) should introduce MediGuard to all patients, 93% responded yes and 89% said that offering the service would positively impact their impression of the NHS (43% significantly, 46% somewhat positive impact). While only 12% have ever enrolled in a trial, 71% were at least somewhat interested in participating in the next 12 months (23% extremely, 17% very, 31% somewhat interested). The primary reason why patients have not enrolled in a trial is lack of awareness (68%); only 16% mentioned lack of participation due to concerns about an experimental drug. **CONCLUSIONS:** Survey results show that engagement in a medicines monitoring service is an effective method for improving outcomes and increasing awareness of clinical trials; pilot studies are now underway. Historically, the NHS has been slow to pursue public-private partnerships, however, NHS efforts to stimulate on-line patient engagement have not been a huge success (e.g., HealthSpace enrolled 3,000 in the first year at a cost of £8 million). Recognizing that all UK countries have initiatives to increase participation in research, perhaps it is time for the NHS to reconsider the role of partnerships to leverage the explosion of web-based applications as a method for stimulating research.

PHP2

RELATION BETWEEN CONSUMER BEHAVIOUR AND DRUG SAFETY MONITORING IN FRANCE

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OBJECTIVES: This study aimed to assess the opinion of the French population on the publication of a list of 77 medicines under regulatory monitoring (surveillance list, published following market withdrawal of diet adjuvant benfluorex) in France and more specifically evaluate its impact on consumer behaviour. **METHODS:** A total of 928 French individuals answered a phone questionnaire consisting of 37 closed questions and 3 open-ended questions. Respondents were aged 30 and over since this age group is expected to be more prone to diseases and chronic pathologies. The study, carried out in March 2011, was compliant with the French National INSEE quota methodology. **RESULTS:** Around 7% of the sample population declared using at least one of the products included in the French surveillance list. Of these, over one in three persons indicated their intention to stop or suspend their treatment in reaction to their medicine's regulatory surveillance while one in three persons did not intend to change their treatment intake. Meanwhile, in the larger study sample, nearly one in six persons declared considering reducing their medicine purchasing patterns as a result of the surveillance list publication, a figure in line with studies conducted prior to the publication of the list. Finally, treatment compliance was reported at 85.8% pre-surveillance list publication and 83.5% post-surveillance list publication. **CONCLUSIONS:** French consumer confidence in pharmaceuticals in general is mostly unaffected by the new surveillance list. However, consumer behaviour is strongly affected by product inclusion onto the surveillance list, especially for those patients treated with at least one listed treatment. Furthermore, consumer confidence in healthcare regulators, off-label prescribing and pharmaceutical companies was negatively affected by the benfluorex case. Prescribers will have a pivotal role in maintaining overall confidence through patient communication and information.

PHP3

PATIENT PREFERENCES CONSIDERING THE CHOICE OF HEALTH CARE PROVIDERS IN HUNGARY– RESULTS FROM DISCRETE CHOICE EXPERIMENT

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OBJECTIVES: We use discrete choice experiment to analyze which attributes (quality, access, and price) influence patients' choice between health care providers. We also estimate the willingness-to-pay of respondents for the improvement of health care characteristics. **METHODS:** Data was collected via household survey conducted by face-to-face interviews in Hungary, 2010. Respondents were selected based on multistage random probability method. In total, 1037 respondents filled in the questionnaire. In DCE, eight choice set for the physician and eight for hospital services were presented to the respondents in the form of alternative and basic profiles that contained combinations of attributes of health care services. Attributes and attribute levels were developed on the basis of literature review. For the analysis binary probit regression with random effects was used including attribute differences as well as interactions of attribute differences and socio-economic characteristic as independent variables. Marginal rates of substitution (MRS) were calculated to indicate the willingness-to-pay of the respondent for the improvements in the attribute levels. **RESULTS:** The response rate of the survey was 67%. Significant negative regression coefficients ($p<0.1$) of the interactions between price and social economic characteristics show that respondents from a village or the capital, with low education and bad health status were more sensitive to changes in the price attribute when choosing between health care providers. MRSs show that respondents are willing to pay the most for the good skills and reputation of the physician and the attitude of the personnel, followed by modern equipments and maintenance of the office/hospital. Access attributes (travelling and waiting time in front of the office) were less important. **CONCLUSIONS:** DCE